MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5656

CERTIFICATE OF DEATH

05644

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace
d. STREET ADDRESS: 613 S Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell — Middle: Samuel — Last: Abbott

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 16 - 1907

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: Abbott Bros

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin ? Abbott

14. MOTHER'S MAIDEN NAME: Catherine MC Nulty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hazel J. Abbott — Address: 613 S. Washington Havre de Grace Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b): Carcinoma of Larynx — 2 1/2 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 161X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..., to ..... 19...., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at 9:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward L. Wardman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. (BURIAL) CREMATION, REMOVAL (Specify): 5/12/61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Mt. Erin

23d. LOCATION (City, town or county) (State): Havre de Grace Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros. — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR: MAY 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G288 6/7/61 iwk

CERTIFICATE OF DEATH

5657

Reg. Dist. No. 05645

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford County Alms House

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pylesville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Hobart — Middle: — Last: Bay

4. DATE OF DEATH: Month: May — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 21, 1896

9. AGE (In years last birthday): 65 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Oliver Alexander Bay

14. MOTHER'S MAIDEN NAME: Fannie Caloway Smithson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-12-5238

17. INFORMANT: Mrs. Ralph Manifold, Stewartstown, Pa.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary sclerosis
DUE TO
(c) Chr. Cardio-vascular Disease — ??

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 2, 19 61 to May 29, 19 61 that I last saw the deceased alive on May 25, 19 61, and that death occurred at 12:30PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: May 29, 1961

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D. — Forest Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 1, 1961
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross
22d. LOCATION (City, town, or county) (State): Rocks, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbaugh — ADDRESS: Delta, Penna.

24a. REC'D BY REGISTRAR DATE: JUN 5 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5653 — 05646

1. **PLACE OF DEATH**
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 21 hrs. 24 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 102 SENECA ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILLIAM	CLAUDE	BOWMAN	MAY	22	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		MAY 22, 1961	yrs.		21 / 24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
BILL E. BOWMAN	NATALIE LEISHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	no	Hosp Records, Havre de Grace Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral anoxia	1 dy
DUE TO (b)	Pneumonitis aspiration	1 dy
DUE TO (c)	Prematurity	

763.5 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occured at 10:24 A.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Irvin L. Wachsman M.D.		5/24/61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
IRVIN L. WACHSMAN M.D	107 S. UNION AVE. HAVRE de GRACE MD.

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
	5/24/61	Angel Hill	Havre de Grace Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pennington Bros, Havre de Grace Md	MAY 29 '61	Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 315 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5659 — Reg. Dist. No. 05647

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
c. LENGTH OF STAY IN 1b: 32 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bush Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS: Bush Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Braxton — Last:
4. DATE OF DEATH: Month: May — Day: 3 — Year: 1961

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: April 17, 1861
9. AGE (In years last birthday): 100 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (State or foreign country): USA Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Elizabeth Harris — Address: Baltimore, Md.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: —
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: Bel Air, Md 5-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May, 7, 1961
22c. NAME OF CEMETERY OR CREMATORY: John Wesley
22d. LOCATION (City, town, or county) (State): Abingdon, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas & Son — Howard K. McComas Jr.
ADDRESS: Abingdon, Maryland.
24a. REC'D BY REGISTRAR DATE: MAY 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain cause. Complete certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5660

CERTIFICATE OF DEATH

11564S

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 116 Beaver St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: J. — Last: Callahan

4. DATE OF DEATH: Month: 5 — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 1/25/1901

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles J. Callahan

14. MOTHER'S MAIDEN NAME: Margaret Bodani

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Joshua Tasker — Address: 116 Beaver St. Havre de Grace Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Parotid Gland — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.
DUE TO
142.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1960 to May 1961, that (I) (we) last saw the deceased alive on 5-29-1961, and that death occured at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-29-61

22c. PHYSICIAN'S NAME (Type): E. J. SIMON

22d. ADDRESS: HAVRE DE GRACE, MD

23a. (BURIAL) CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: June 1, 1961

23c. NAME OF CEMETERY OR CREMATORY: St. John Catholic

23d. LOCATION (City, town or county) (State): Long Green Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Langley Bros, Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0564

1. PLACE OF DEATH — a. COUNTY: Harford — 5661 — Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN MARYLAND: 70 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, Md.
d. STREET ADDRESS: 622 Ontario — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Chapman — Last: Caponie

4. DATE OF DEATH — Month: 5 — Day: 29 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 3, 1890

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR — Months: — Days:

IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Post Office Dept.

11. BIRTHPLACE (County & State, or foreign country): Casons Dam Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Chapman Caponie

14. MOTHER'S MAIDEN NAME: Mary C. Flarity

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Lena Caponie — Address: 622 Ontario St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 7, 19 54 to 3-29-, 19 61 that (I) (we) last saw the deceased alive on 3-29, 19 61, and that death occured at ....M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 6/2/61 — 23c. NAME OF CEMETERY OR CREMATORY: Angel Hill — 23d. LOCATION (City, town or county) (State): Havre de Grace Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR — DATE JUN 5 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5662

CERTIFICATE OF DEATH

Reg. Dist. No. 05650

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 14 N. Union
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herman Middle H. Last Case

4. DATE OF DEATH: Month 5 Day 12 Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/2/1887

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Advertising

11. BIRTHPLACE (State or foreign country): Towanda Penn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson B Case

14. MOTHER'S MAIDEN NAME: Mary E. Esky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hattie L. Case — Address: 908 W. James St., Lancaster Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cardio Vascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/ 1959 to 6-12 1961 that I last saw the deceased alive on 4-7 1961, and that death occurred at M, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE: [signature] M.D.

PHYSICIAN'S NAME (Type): [signature]

22a. (BURIAL) CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/14/61

22c. NAME OF CEMETERY, OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: MAY 18 '61

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5663 — 65651

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #2 Box 300

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: Route #2 Box 300
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: H. — Last: Ceris Sr.

4. **DATE OF DEATH**: Month: 5 — Day: 1 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 1, 1896

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Army Chemical Center

11. BIRTHPLACE (City & State, or foreign country): Harford County

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Benjamin Ceris

14. MOTHER'S MAIDEN NAME: Hannah Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes WW I

16. SOCIAL SECURITY NO: 220-01-5788

17. INFORMANT: Mrs. Mary E. Ceris, Street, Md. — Address: Rt 2 Box 300

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH

.03X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular disease

DUE TO (c): Renal Insufficiency

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.V.A.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/14 ..., 1960 to 5/1 ..., 1961, that (I) (we) last saw the deceased alive on 4/28 ..., 1961, and that death occured at 7:30 PM, from the causes and on the date stated above

22a. SIGNATURE: George T. Stansbury.

22b. DATE SIGNED: 5/2/61

22c. PHYSICIAN'S NAME (Type): George T Stansbury

MD — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22d. ADDRESS: 1509 Revolution St Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-6-61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Cemetery

23d. LOCATION (City, town or county) (State): Darlington, Harford Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Elmer T Bullock, Havre de Grace Md.

ADDRESS: 556 Lewis St.

25a. REC'D BY REGISTRAR — DATE: MAY 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5664

CERTIFICATE OF DEATH

05652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 324 Superior, ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 324 SO PERIOR, ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL Middle GOLDSMITH Last CURRY

4. DATE OF DEATH: Month MAY Day 12 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 29 1892

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEPHONE REPAIRMAN

10b. KIND OF BUSINESS OR INDUSTRY: A.T.&T. RETIRED

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN SAMUEL CURRY

14. MOTHER'S MAIDEN NAME: MARGARET LEE WRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 213-05-7273

17. INFORMANT: Mrs. Lottie L. Curry — Address: 324 Superior ST Havre de Grace, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Occlusion

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-12 1961, to 5-12 1961, that (I) (we) last saw the deceased alive on 5-12 1961, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 5-13-61

22c. PHYSICIAN'S NAME (Type): DR. C HIRSCH

22d. ADDRESS: 421 CONGRESS AVE. HAVRE DE GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 15 1961

23c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM.

23d. LOCATION (City town, or county): HARFORD (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, MD

25a. REC'D BY REGISTRAR: MAY 17 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Frame

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5665

CERTIFICATE OF DEATH

05653

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
d. STREET ADDRESS: R.D. 1 ~~XXXXXXXXX~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Augusta — Last: Deckman

4. DATE OF DEATH: Month: 5 — Day: 25 — Year: 1961.

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24, 1878

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~XXXXXXXXXX~~ Housewife, Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John F. Finkernagel

14. MOTHER'S MAIDEN NAME: Amelia H. Oales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defense service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Frances C. Preston, Address 627 Jennifer Lane, Aberdeen, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO (b): Rt. Supracondylar Fracture — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Generalized Osteoporosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Dementia due to Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/20/61 to 5/25/61, that (I) (~~was~~) last saw the deceased alive on 5/25/61, and that death occured at 7:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. H. Sadowsky M.D.

22b. DATE SIGNED: May 25, 1961

22c. PHYSICIAN'S NAME (Type): W. H. SADOWSKY

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: 504 Lewis St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 5/27/61

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery

23d. LOCATION (City, town or county) (State): Havre de Grace, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John F. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5666

CERTIFICATE OF DEATH

05654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 31 - Rural # 2

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Box 31 - Rural # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martin; Middle: Gregory; Last: Jonathue

4. DATE OF DEATH: Month: ✓; Day: 11; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6/10/1896

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Govt. etc.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bernard Jonathue

14. MOTHER'S MAIDEN NAME: Emma Wise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give wars or dates of service): Yes War I

16. SOCIAL SECURITY NO: 214-14-0747

17. INFORMANT: Gertrude K. Jonathue - Aberdeen
Address: Rural # 2 - Box 31

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: One hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertention
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1956

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March, 1938 to May, 1961, that (I) (we) last saw the deceased alive on May 7, 1961, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Andre Weiss M.D.

22b. DATE SIGNED: May 12, 1961

22c. PHYSICIAN'S NAME (Type): ANDRE WEISS M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 114 N. Bel Air Av. Aberdeen

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens, RD.

23d. LOCATION (City, town or county): Havre de Grace

(State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John G. Tarring - Aberdeen, Md. — Tarring Funeral Home

25a. REC'D BY REGISTRAR DATE: MAY 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5667 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05655

Item 9 Film G288 5/29/61

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Johnson's Mill Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Johnson's Mill Road
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Izetta — Middle: Rose — Last: Dowell

4. DATE OF DEATH: Month: May — Day: 22 — Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6 1907

9. AGE (In years last birthday): 54 3rd

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework at Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Allegheny Co, M.C. USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emory Burchew

14. MOTHER'S MAIDEN NAME: Laval Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Mack Dowell — Address: Bel Air Md R 10

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 5-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: May 25, 1961

22c. NAME OF CEMETERY OR CREMATORY: Sparta M.C.

22d. LOCATION (City, town, or country) (State): M. C.

23. FUNERAL DIRECTOR: H. L. Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR: DA MAY 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5668 — 65656

1. **PLACE OF DEATH** a. COUNTY: Harford — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN this place: 2 days — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp — MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Harford — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — d. STREET ADDRESS: 428 S. Union Ave — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Martin — Middle: P — Last: Foley

4. **DATE OF DEATH**: Month: 5 — Day: 1 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 5/13/1904

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: Program Director of Handicap Van Trucks

11. BIRTHPLACE (County & State, or foreign country): Md-Harford Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin P. Foley

14. MOTHER'S MAIDEN NAME: Ellen Koendess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis
DUE TO (b): Chronic Paralytic Ileus
DUE TO (c): Dehydration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prolonged Diuretic Administration

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11 AM May 1, 1961 to ..... 10 PM May 1, 1961 that (I) (~~saw~~) last saw the deceased alive on May 1, 1961, and that death occured at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE: J H Sadowsky M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 2, 1961

22c. PHYSICIAN'S NAME (Type): J H Sadowsky M.D.

22d. ADDRESS: 504 Lewis St Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/4/61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Erin

23d. LOCATION (City, town or county) (State): Havre de Grace Md

24. FUNERAL DIRECTOR'S SIGNATURE: Funeral Home

ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5665

CERTIFICATE OF DEATH

45657

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSP.
MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Girl; Middle:; Last: HENRY

4. DATE OF DEATH: Month: MAY; Day: 8; Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5-6-61

9. AGE (In years last birthday) yrs.; IF UNDER 1 YEAR: Months; Days: 2; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: JOSEPHINE SUTTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Josephine Sutton Address: Darlington

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coarctation, Subtotal of aorta
DUE TO (b): Patent ductus arteriosus
DUE TO (c): CONGENITAL ANOMALY

Condition may, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: at birth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 6, 1961 to MAY 8, 1961, that (I) (~~was~~) last saw the deceased alive on MAY 8, 1961, and that death occured at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: Frank Wolbert M.D.

22b. DATE SIGNED: MAY 9. 1961

22c. PHYSICIAN'S NAME (Type): FRANK WOLBERT M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: HAVRE DE GRACE MARYLAND

23a. BURIAL (CREMATION) REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 8, 1961

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Hospital

23d. LOCATION (City, town or county) (State): Havre de Grace, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Harry R Tully

ADDRESS: administrator

25a. REC'D BY REGISTRAR DATE: MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5670 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05658

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Old Bay Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Calvin — Middle: — Last: Hill

4. DATE OF DEATH: Month: May — Day: 5 — Year: 19 61

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan 29, 1961

9. AGE (If years last birthday): X yrs. — IF UNDER 1 YEAR: Months: 3 Days: 9 — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: dupont

11. BIRTHPLACE (State or foreign country): Havre de Grace, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willis D. Hill

14. MOTHER'S MAIDEN NAME: Shirley Lee Gerald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Willis D. Hill — Address: Old Bay Farm - Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city town o county): Bel Air, Md.

DATE SIGNED: 5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/10/61

22c. NAME OF CEMETERY OR CREMATORY: A.P.G. Cemetery

22d. LOCATION (City, town, or country) (State): Aberdeen Proving Ground, Md

23. FUNERAL DIRECTOR: Elmer E Bullock — ADDRESS: Havre de Grace, Md

24a. REC'D BY REGISTRAR — DATE: MAY 15

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5671 Reg. Dist. No. 0565

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Darlington
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Darlington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Otis Henry [illegible] Middle: Last: Hunt

4. DATE OF DEATH: Month: May Day: 4, Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5, 1897

9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aberdeen P.G.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Henry otis Hunt

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 003-01-0647

17. INFORMANT: Address: Mrs Gale Hunt Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Rheumatic endocarditis and myocarditis(Chronic) — ??
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 2, 19 50, to May 1961, 19 ____ that I last saw the deceased alive on May 6, 1960, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. ADDRESS (Street, city or town, state): Forest Hill, Md. DATE SIGNED: 5/5/61

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): May 8, 1961

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Bel-Air Memorial at Harford

22d LOCATION (City, town, or county) (State): Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey ADDRESS: Darlington, Md.

24a. REC'D BY REGISTRAR DATE: MAY 10 '61

24b. REGISTRAR'S SIGNATURE: Collins S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5672

CERTIFICATE OF DEATH

Reg. Dist. No. 05661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 99 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 217 N. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bennett — Middle: Aquila — Last: Keen

4. DATE OF DEATH: Month: 5 — Day: 21 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 2/18/1862

9. AGE (In years last birthday): 99 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Waterman

11. BIRTHPLACE (State or foreign country): Aberdeen

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Aquila Keen

14. MOTHER'S MAIDEN NAME: Charlotte Johnson Mary Joyner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown; if yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Eden Keen — Address: 217 N. Union Ave., Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Insufficiency
DUE TO (b): Age
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____ 19__ to _____ 19____, that I last saw the deceased alive on 5/18/61, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Harford Grace MD

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/23/61

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: [signature] Havre de Grace Md

24a. REC'D BY REGISTRAR DATE: MAY 25 '61

24b. REGISTRAR'S SIGNATURE: Clinton S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5673

CERTIFICATE OF DEATH

Reg. Dist. No. 05661

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Street
c. LENGTH OF STAY IN 1b: 76 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.#2

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural- Street
d. STREET ADDRESS: R.D.#2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle HENRY — Last KOHLBUS

4. DATE OF DEATH: Month May — Day 23, — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 3,1885

9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Kohlbus

14. MOTHER'S MAIDEN NAME: Elizabeth Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-07-0294

17. INFORMANT: Address: Mrs. Paul Iddings, Street, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1961 to May 22 1961 that I last saw the deceased alive on May 22, 1961, and that death occurred at 4 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Hyson M.D. — ADDRESS (Street, city or town, state): Fawn Grove, Pa. — DATE SIGNED: 5/24/61

PHYSICIAN'S NAME (Type): Edward W. Hyson — Fawn Grove, Penna.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 25,1961

22c. NAME OF CEMETERY OR CREMATORY: Emory

22d. LOCATION (City, town, or county) (State): Street, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbine — ADDRESS: elta, Penna.

24a. REC'D BY REGISTRAR DATE: MAY 26 '61

24b. REGISTRAR'S SIGNATURE: Cora L. Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5674

CERTIFICATE OF DEATH

Reg. Dist. No. 05662

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: VJ Mt Royal Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: VJ Mt. Royal Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Claude — Last: Krauss

4. DATE OF DEATH: Month: May — Day: 8th — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/14/1901

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber, Self employed

10b. KIND OF BUSINESS OR INDUSTRY: Barber

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: John Krauss

14. MOTHER'S MAIDEN NAME: Annie Suder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-16-9442

17. INFORMANT: Velma Palmer Krauss — Address: VJ Mt. Royal Ave Aberdeen Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO (b): Coronary Occlusion — 5 minutes
DUE TO (c): Coronary Arteriosclerosis — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19__ to 5-8, 1961, that I last saw the deceased alive on 5-8-1961, and that death occurred at 1:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D.
ADDRESS (Street, city or town, state): 8 Law St. Aberdeen, Md.
DATE SIGNED: 5-8-61
PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/11/61
22c. NAME OF CEMETERY OR CREMATORY: Babers Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen. Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Carring — ADDRESS: Aberdeen. Maryland

24a. REC'D BY REGISTRAR — DATE: MAY 12 '61
24b. REGISTRAR'S SIGNATURE: Chas L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5675 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05664

FOR STATE HEALTH DEPT. M

1

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Memorial Hospital c. LENGTH OF STAY IN 1b 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE N. C. b. COUNTY Iredell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Statesville
d. STREET ADDRESS 1218 Broad Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First David Middle Ivey Last Lanier

4. DATE OF DEATH Month May Day 18 Year 1961

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct. 24, 1912

9. AGE (In years last birthday) 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver

10b. KIND OF BUSINESS OR INDUSTRY trucking

11. BIRTHPLACE (State or foreign country) Iredell Co.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME M. M. Lanier

14. MOTHER'S MAIDEN NAME Dora Hawthorne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractures pelvis + femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2 logs fell on him

20c. TIME OF INJURY Hour 5 p.m. Month, Day, Year 5-12 1961

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rising Sun

20f. (City or town) Rising Sun (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M D

EXAMINER'S NAME (Type) Gerald E Palmer M.D

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED 5-19-61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF May 20, 1961

22c. NAME OF CEMETERY OR CREMATORY Abilene Ch. of Christ Cem.

22d. LOCATION (City, town, or county) Iredell Co. (State) N. C.

23. FUNERAL DIRECTOR Pennington & Son, Harde de Grace Md. ADDRESS

24a. REC'D BY REGISTRAR DATE MAY 22 '61

24b. REGISTRAR'S SIGNATURE Clinton S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film G288 ... 1WK

5676

CERTIFICATE OF DEATH

Reg. Dist. No. 05667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 41 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace R. 1
d. STREET ADDRESS: 701 Erie
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernadina Middle: L. Last: Leonardi

4. DATE OF DEATH: Month: 5 Day: 17 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/28/1884

9. AGE (In years last birthday): 76 yrs. 8 mos.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Daniel Levi

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Kay Revolinski — Address: Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA of BLADDER — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
181.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December, 1960, to 5-17, 1961, that I last saw the deceased alive on 5-17, 1961, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D. Hirsch M.D. — ADDRESS (Street, city or town, state): 421 Congress Av. — DATE SIGNED: 5-18-61

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/20/61

22c. NAME OF CEMETERY OR CREMATORY: Fairview

22d. LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas H. Kay — ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR — DATE: MAY 19 '61

24b. REGISTRAR'S SIGNATURE: Charles J. Krause

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05665

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air Rt 2
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ner home Fountain Green

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air, Fountain Green
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alma Virginia; Middle: ; Last: Lewis

4. DATE OF DEATH: Month: May; Day: 1; Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb 29 1880

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Independence, Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Smith dead

14. MOTHER'S MAIDEN NAME: Emily Wilcox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: –

17. INFORMANT: Mrs Mina Jessee, Address: Bel Air RD 2 Bel Air

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular disease
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☐. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL EXAMINER'S SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Bel Air, Md

DATE SIGNED: 5-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/4/1961

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or country): Bel Air (State): Md.

23. FUNERAL DIRECTOR: Charles E. Kurtz ADDRESS: Jarrettsville, Md.

24a. REC'D BY REGISTRAR DATE: MAY 4 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 4 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5678

CERTIFICATE OF DEATH

Reg. Dist. No. 05666

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 642 N. Adams St.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace
d. STREET ADDRESS: 642 N. Adams St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: J. — Last: Lewis

4. DATE OF DEATH: Month: May — Day: 18 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 20, 1885

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Engineer.

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John F. Lewis

14. MOTHER'S MAIDEN NAME: Josephine Jamison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1903-1907

16. SOCIAL SECURITY NO.: None

INFORMANT: Ada P. Lewis, 642 N. Adams St. Havre De Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 3yrs.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arterio Sclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to May 17, 19 61 that I last saw the deceased alive on May 17, 19 61, and that death occurred at 3:15 A M, from the causes and an the date stated above.

ACTUAL SIGNATURE: Clarence I. Benson M.D — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Clarence I. Benson. M.D. — Port Deposit, Md — 5/19/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-21-1961

22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son

ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: MAY 23 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5679

CERTIFICATE OF DEATH

05668

1 M I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: MARYLAND 7 Yrs 35 M.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 200 S. Stokes St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marguerite Middle: H. Last: McComas

4. DATE OF DEATH: Month: MAY Day: 2 Year: 1961

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 26, 1906
9. AGE (In years, last birthday): 54 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WALTER HAINES
14. MOTHER'S MAIDEN NAME: EMILY COALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: WILLIAM E. McCOMAS Address: HAVRE DE GRACE, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	acute pulmonary edema	1 day
DUE TO (b)	acute cardiac failure	1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Carcinomatosis	4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 56 to MAY 2, 1961, that (I) (we) last saw the deceased alive on MAY 2, 1961, and that death occured at 12:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-2-61
22c. PHYSICIAN'S NAME (Type): EDWARD J. SIMON
22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 5, 1961
23c. NAME OF CEMETERY OR CREMATORY: Mountain Christian Ch. Yd.
23d. LOCATION (City, town or county) (State): HARFORD Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison McKehull ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: MAY 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

17

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 by im 6207 5/22/61 mh

V5662

M

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve de Grace
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 60 E Bel Air Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evan; Middle: M; Last: Mitchell

4. DATE OF DEATH: Month: May; Day: 7; Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 29, 1914

9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Canner-Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Cannery & Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Malcolm Mitchell

14. MOTHER'S MAIDEN NAME: Eva Osborn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-32-1619

17. INFORMANT: Lillian B. Mitchell, Address 60 E. Bel Air Ave Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1st, 2nd, & 3rd degree burns

DUE TO (b): chest & upper extremities

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Tapicab caught fire

20c. TIME OF INJURY Hour a.m. p.m. 4-27 1961 — Month, Day, Year

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 20f. (City or town) Aberdeen (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county): Bel Air, Md.

DATE SIGNED: 5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 10, 1961

22c. NAME OF CEMETERY OR CREMATORY: Grove Cemetery

22d. LOCATION (City, town, or country) (State): Aberdeen, Maryland

23. FUNERAL DIRECTOR: John G. Tarring — ADDRESS: Tarring Funeral Home Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAY 12 '61

24b. REGISTRAR'S SIGNATURE: Clarence S. Krauss

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and [illegible] to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form [illegible]. Page [illegible] may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: MARYLAND 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 136 Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle B Last Mitchell

4. DATE OF DEATH: Month May Day 3 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-5-72

9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR, Months / Days
IF UNDER 24 HRS., Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Josiah Bell

14. MOTHER'S MAIDEN NAME: Cornelia Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary F. Kaiser, 4212 Harcourt Rd. Address: Balto. 14, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of femur — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary occlusion. Pyuria. Pericarditis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell in her home

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 4-17 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Aberdeen (County) Ha. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air Md

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 5-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/6/61

22c. NAME OF CEMETERY OR CREMATORY: Grove Presbyterian Cemetery,

22d. LOCATION (City, town, or country) Aberdeen, Md. (State)

23. FUNERAL DIRECTOR: John G. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAY 8 '61

24b. REGISTRAR'S SIGNATURE: Arthur L Krapf

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5682

CERTIFICATE OF DEATH

05671

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen,
d. STREET ADDRESS: Chesapeake Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle E. — Last OLIVER

4. DATE OF DEATH: Month May — Day 12, — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1875

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James William Oliver

14. MOTHER'S MAIDEN NAME: Sarah McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: ** **

17. INFORMANT: Mrs. C.E. Oliver, Chesapeake Rd.

Address: Aberdeen, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebr-vascular accident
DUE TO (b): Arterio-sclerotic Cerebr-vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): with Hypertension

INTERVAL BETWEEN ONSET AND DEATH: 9 day / 9 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept ..... 19 61 to May ..... 19 61, that (I) (we) last saw the deceased alive on May 12 19 61, and that death occured at 2:55 PM, from the causes and on the date stated above.

22a. SIGNATURE: J. Ralph Horky M.D.

22b. DATE SIGNED: May 12, 1961

22c. PHYSICIAN'S NAME (Type): J.Ralph Horky, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Churchville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery

23d. LOCATION (City, town or county): Perryman, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
John G. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 16 '61

25b. REGISTRAR'S SIGNATURE: Luther L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

TO DE[illegible] [illegible]DICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary: please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5683

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05672

1. PLACE OF DEATH
a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.D.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: RD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Regina Middle: B. Last: Rice

4. DATE OF DEATH Month: May Day: 11 Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2-23-61
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR Months: 2 Days: — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): HAVRE DE GRACE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANCIS RICE
14. MOTHER'S MAIDEN NAME: BETTY STEHLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: FRANCIS RICE, Address: STREET, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia
X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 5-11-61
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
Address (Street, city, town, or county): Bel Air Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-13-61
22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE
22d. LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR: John H. Hawkins, ADDRESS: Delta, Penna.
24a. REC'D BY REGISTRAR DATE: MAY 12 '61
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5684

CERTIFICATE OF DEATH

Reg. Dist. No. 0567 3

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 1958
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 610 Law Street

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a STATE: Maryland — b COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen.
d STREET ADDRESS: 610 Law Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Winnie — Middle: Beatrice — Last: Richards
4 DATE OF DEATH: Month: J — Day: 11 — Year: 1961
5. SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 3/29/1880
9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: Min:
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Nova Scotia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Herman Leary
14. MOTHER'S MAIDEN NAME: Mary Jane (Unknown)
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO: 032-10-5785
17 INFORMANT: Address: Mrs Irving F. Hill - 610 Law St. Aberdeen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic Cardiovascular disease — > 5 yrs
DUE TO (c):
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 332
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour, a m, p m, 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 5-7-61, 19____, to 5-11-61, 19____, that I last saw the deceased alive on 5-7-61, 19____, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B J Plunkett Jr M.D. — ADDRESS (Street, city or town, state): 617 W. Bel Air Ave. — DATE SIGNED: 5-12-61
PHYSICIAN'S NAME (Type): B.J. Plunkett Jr., M.D. Aberdeen, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5/12/61
22c NAME OF CEMETERY OR CREMATORY: Cherry Valley Cemetery
22d. LOCATION (City, town, or county) (State): Cherry Valley Mass.
23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home Aberdeen, Maryland
24a REC'D BY REGISTRAR DATE: MAY 16 '61
24b REGISTRAR'S SIGNATURE: Anthony S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5685

CERTIFICATE OF DEATH

05674

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 1½ DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HAZEL — Middle: A. — Last: RICKETTS

4. DATE OF DEATH: Month: MAY — Day: 7 — Year: 1961

5. SEX: FEMALE — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: May 12, 1894 — 9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Home — 11. BIRTHPLACE (County & State, or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: C. Arlie Aaronson — 14. MOTHER'S MAIDEN NAME: Pearl Mallick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: ** ** — 17. INFORMANT: Clifford Ricketts, Perryman, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acidosis	2 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	Anuria	2 days
(c)	Diabetes Mellitus (Kimmelstiel-Wilson Syndrome)	6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1948, 19.., to 5-7-, 1961, that (I) (we) last saw the deceased alive on 5-6-, 19 61, and that death occured at 1.35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5-8-61

22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D. — 22d. ADDRESS: 8 Law St., Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 9, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery — 23d. LOCATION (City, town or county) (State): Perryman, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Glen A. Tarring — Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 12 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3686

CERTIFICATE OF DEATH

05675

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 16½ HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
d. STREET ADDRESS: B of 309 R.D 3
IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RINE Middle HART Last

4. DATE OF DEATH: Month MAY Day 22 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-21-61

9. AGE (In years last birthday) yrs | IF UNDER 1 YEAR, Months, Days | IF UNDER 24 HRS. Hours, Min.: 16 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not rec'd)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country): HARFORD Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES RINEHART

14. MOTHER'S MAIDEN NAME: EVELYN LEONARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): NO

16. SOCIAL SECURITY NO

17. INFORMANT: Mr. Charles Rinehart, Bel Air Rural, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ANENCEPHALUS — INTERVAL BETWEEN ONSET AND DEATH: 15 HOURS

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAY 21 ..., 1961, to MAY 21 ..., 1961, that (I) (we) last saw the deceased alive on MAY 21 ..... 1961, and that death occured at 6:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip W. Heuman M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: MAY 22, 1961

22c. PHYSICIAN'S NAME (Type): PHILIP W. HEUMAN M.D

22d. ADDRESS: 307 HICKORY, BEL AIR, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: MAY 23, 1961

23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Cemetery

23d LOCATION (City, town or county) (State): Hickory, Harford Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster

ADDRESS: W. Broadway & Williams St. Bel Air, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5687 **CERTIFICATE OF DEATH** 05676

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 634 Colaine Drive

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 634 Colaine Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JOSEPH — Middle — Last SCARLATA

4. **DATE OF DEATH**: Month May — Day 31 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 15, 1890

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber, (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Barber

11. BIRTHPLACE (County & State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give wer or dates of service)

16. SOCIAL SECURITY NO: 087-28-9110

17. INFORMANT: Mary Phillips, 634 Colaine Drive Aberdeen, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 199X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Abdominal Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH: ~ 4 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-12-61, 19..... to 5-31-, 19 61, that (I) (We) last saw the deceased alive on 5-31-1961, and that death occured at 7:45 PM from the causes and on the date stated above.

22a. SIGNATURE: B.J. Plunkett Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-1-61

22c. PHYSICIAN'S NAME (Type): B.J. Plunkett Jr. M.D.

22d. ADDRESS: 617 W. Bel Air Ave, Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 6/1/61

23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery

23d. LOCATION (City, town or county) (State): Poughkeepsie, New York

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/110

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5688 **CERTIFICATE OF DEATH** 05677

1 (M)

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural -Street
c. LENGTH OF STAY IN 1b: 61 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Street.
d. STREET ADDRESS: Grier Nursery Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EDWARD	W.	STEWART	May	2,	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Male	White		May 31, 1899	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Auto mechanic		Street, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James W. Stewart	Lillis D. Iley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-22-3099	Mrs. Edward W. Stewart, Street, Md.

(I)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible] DUE TO (b) [illegible]

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) [illegible]

INTERVAL BETWEEN ONSET AND DEATH: [illegible] (2 years)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) [illegible] (accepted via 12 yrs)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 1957, 19.., to May 2, 19.., that (I) (we) last saw the deceased alive on May 1, 19 61, and that death occured at 2:0 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D. ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5-5-61

22c. PHYSICIAN'S NAME (Type): Benj. Dorogi

22d. ADDRESS: Cardiff, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	May 5, 1961	Highland	Street,	Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Hartline — ADDRESS: Delta, Pa.

25a. REC'D BY REGISTRAR DATE: MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5688 — 05678

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: MARYLAND 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 418 N Stokes St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earle — Middle: M — Last: Stirling

4. DATE OF DEATH: Month: May — Day: 18 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 31 - 1890

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (City & State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Stirling

14. MOTHER'S MAIDEN NAME: Hannah (Smith) Stirling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Chas O. Stirling — Address: 418 N. Stokes Havre de Grace, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, left upper lobe — INTERVAL BETWEEN ONSET AND DEATH: 10 days.
DUE TO (b): IX
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis with cavities, left

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MED.CAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/8/61 19 . to 5/18 ..., 1961, that (I) (~~saw~~) last saw the deceased alive on 5/18 ..., 1961, and that death occured at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Edward E. Loo M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/19/61

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 5/21/61

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City, town or county) (State): Havre de Grace, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Thomas Dan, Havre de Grace Md

ADDRESS:

25a. REC'D BY REGISTRAR DATE MAY 23 '61

25b. REGISTRAR'S SIGNATURE: Caitlin S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5690

CERTIFICATE OF DEATH

056719

1 M I

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN this place: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address, etc.): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXXX Bel Air
d. STREET ADDRESS: Rt #1, Box 164
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Franklin — Last: Supik
4. DATE OF DEATH: Month: May — Day: 16 — Year: 1961

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1881
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Blacksmith (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Farm & Shop
11. BIRTHPLACE (County & State, or foreign country): [redacted] Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Supik
14. MOTHER'S MAIDEN NAME: Carrie Dypk (Sdec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service.): No
16. SOCIAL SECURITY NO.: 215-22-6951
17. INFORMANT: John F. Supik Jr., RD 2, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Failure & Arteriosclerotic Heart Disease	
DUE TO (b)	Pulmonary Edema	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Chronic Lung Disease (Emphysema)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Suppurative Cholecystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/9/61 19 to 5-16-61 19 that (I) (we) last saw the deceased alive on ..... 19 ....., and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank D. Hauber M.D.
22c. PHYSICIAN'S NAME (Type): Frank D. Hauber, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 610 S. Union Ave, Havre de Grace, Md.
22b. DATE SIGNED: 5-17-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 19, 1961
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City, town or county) (State): Bel Air, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home, Aberdeen, Md.
John G. Tarring

25a. REC'D BY REGISTRAR DATE: MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Anton S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
15M 9/[redacted]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5691

CERTIFICATE OF DEATH

05650

(M)

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outs de corporate limits write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Chapel Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise; Middle: Thompson; Last:

4. DATE OF DEATH: Month: May; Day: 24; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 4, 1895

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Yeager

14. MOTHER'S MAIDEN NAME: Ida (Shavell) Yeager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 1- Bronchopneumonia

DUE TO: 2- A.S.C.V.D. and H.C.V.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 days / 7 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus & Chronic Cholecystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 17th 1961 to May 24th 1961, that (I) (~~saw~~) last saw the deceased alive on May 24th 1961, and that death occured at 12:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/24/61

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/28/61

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town or county) (State): R.D. Bel Air, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John T. Tarring

ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5692 Reg. Dist. No. 5681

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magnolia
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Magnolia
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clinton; Middle: Alexander; Last: Turner

4. DATE OF DEATH: Month: May; Day: 3; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 27, 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Operator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Turner

14. MOTHER'S MAIDEN NAME: Alice Stauffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-20-7020

17. INFORMANT: Mrs. Clinton Turner — Address: Magnolia, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Gastrointestinal Hemorrhage.
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/26, 19__, to 5/3, 1961, that I last saw the deceased alive on 4/26, 1961, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Louis Kahan M.D.
ADDRESS (Street, city or town, state): Box 966 Edgewood
DATE SIGNED: 5/3/61

PHYSICIAN'S NAME (Type): E. Louis Kahan — Edgewood, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 6, 1961
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial
22d. LOCATION (City, town, or county) (State): Abingdon, Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas & Son — ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR DATE: MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5693 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05682

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 17.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
d. STREET ADDRESS: 07X-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gregor — Middle Yolen-W. — Last Wilson

4. DATE OF DEATH: Month May — Day 12 — Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-16-1915

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Const. Co.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Abe Wilson

14. MOTHER'S MAIDEN NAME: Bine Holcomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes — World war I

16. SOCIAL SECURITY NO.: 234205787

17. INFORMANT: Mrs. S. Ella Wilson — Address: Rising Sun Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture, skull — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Crushing injury chest. Fracture R humerus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident

20c. TIME OF INJURY Hour a.m. p.m. 4 — Month, Day, Year 5-17-1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) — (County): Cecil — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

Address (Street, city, town, or county):

DATE SIGNED: 5-12-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-16-1961

22c. NAME OF CEMETERY OR CREMATORY: Mingo Cem.

22d. LOCATION (City, town, or country): Mingo — (State): West Virg.

23. FUNERAL DIRECTOR: Vernon E McMillen — ADDRESS: Rising Sun, Md.

24a. REC'D BY REGISTRAR DATE: MAY 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Flowers

TO DIRECTOR OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60